

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011719
STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 972

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RICHMOND HEIGHTS		c. CITY OR TOWN 4505 RICHMOND HEIGHTS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARYS HOSPITAL		d. STREET ADDRESS (If outside, give location) 8733 RED BUD	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH G HEIMBURGER			4. DATE OF DEATH Month Day Year APRIL 7 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAR 26 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ADVERTISING AGENT		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI
13a. FATHER'S NAME PETER HEIMBURGER		13b. MOTHER'S MAIDEN NAME ELIZABETH KIEL	14. NAME OF HUSBAND OR WIFE unk.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR I		16. SOCIAL SECURITY NO. 494-03-7663A	17. INFORMANT Address IDA HEIMBURGER 8733 RED BUD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma			INTERVAL BETWEEN ONSET AND DEATH 8 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? 1621 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from March 1959 to April 1959 and last saw him alive on 7 April 59 Death occurred at 6 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Arch M. Ahern, M.D.		22b. ADDRESS 3915 Watson Rd	22c. DATE SIGNED 8 April 59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APRIL 10 1959	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM	23d. LOCATION (City, town, or county) (State) ST. LOUIS CO MO
24. FUNERAL DIRECTOR Thomas Kutis	ADDRESS 2906 Gravois	25. DATE RECD. BY LOCAL REG. 4-9-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
James E. Will

Licensed Embalmer No. 4347
P. O. Address 2906 Dawn

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.